STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445260	A. BUILDING _____ B. WING _____	09/25/2013

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BRIARCLIFF HEALTH CARE CENTER	100 ELMHURST DR OAK RIDGE, TN 37830

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F 000	INITIAL COMMENTS During the annual survey and complaint #32311, #32409, #32350 investigation conducted on September 23, 2013 to September 25, 2013, at Briarcliff Heath Care Center, no deficiencies were cited in relation to complaint #32311. Deficiencies were cited in relation to complaint #32409, and #32350, under CFR part 483.13, Requirements for Long Term Care.	F 000	This Plan of correction is prepared and executed because it is required by the provisions of State and Federal law, and not because Briarcliff Healthcare Center agrees with the allegation(s) and citation(s) listed on this statement of deficiencies. Briarcliff Healthcare Center maintains that the alleged deficiencies do not individually or collectively constitute substandard care or jeopardize the health and safety of the residents; nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also serve as the facility's written credible allegation of compliance.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to allow one resident (#138) to choose a shower schedule consistent with the resident's preferences of forty-three residents reviewed. The findings included: Resident #138 was admitted to the facility on June 26, 2013, with diagnoses including Bilateral Above the Knee Amputations, Diabetes, Peripheral Vascular Disease, History of Cerebrovascular Disease, Anxiety and Depression.	F 242	**F242 Self Determination-Right to make choices** Resident #138 shower schedule was adjusted on 10/7/13 to reflect his preference to receive a shower three times per week. All in house residents will be interviewed to review their shower preference to be completed by DON or designee. All staff will be in serviced by staff development coordinator or designee on importance of resident's right to make choices about aspects of their life that are significant to them; shower schedule.	10/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Melissa Jones | Administrator | 10/11/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	Continued From page 1 Medical record review of the admission Minimum Data Set (MDS) dated July 3, 2013, revealed the resident scored a fifteen on the Brief Interview for Mental Status (BIMS), indicating the resident was independent with daily decision making, required extensive assistance of two persons for transfers, was totally dependent for bathing, and it was very important to choose between a tub bath, shower, bed bath, or sponge bath. Observation and interview on September 23, 2013, at 2:22 p.m., with the resident, in the resident's room, revealed the resident lying on the bed, and stated did not choose how many times a week received a shower. Continued interview revealed the resident would like a shower three or four times a week and only received two showers weekly. Continued interview revealed the resident had told Certified Nursing Assistant (CNA) #1 would like to receive three showers weekly. Continued interview with the resident on September 24, 2013, at 4:00 p.m., revealed the resident felt "dirty" at times due to only receiving two showers weekly. Telephone interview on September 24, 2013, at 4:20 p.m., with CNA #1, revealed the resident had voiced a request to receive showers three times a week. Continued interview revealed the resident's request had been reported to Registered Nurse (RN) #1. Interview on September 24, 2013, at 4:30 p.m., with RN #1, in the hallway, confirmed the resident received a shower twice weekly on Tuesdays and Fridays, and confirmed the resident did not receive showers three times weekly.	F 242	Resident shower preference will be established on admission by the unit manager. This information will be added to unit shower schedule. DON or designee will audit resident shower schedule preference 4 residents 3x week x 4 weeks, 4 residents 2x week x 4 weeks, 4 residents 1x week x 4 weeks then re-evaluate continued need to audit based on findings. Results of audits will be reviewed at Continuous Quality Improvement meeting monthly x 3 months then quarterly thereafter if needed. Continuous Quality Improvement meeting comprised of the DON, Medical Director, and Risk manager, Social Service Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care Nurse, Medical Records Director and Administrator of Quality Assurance.	
F 244	483.15(c)(6) LISTEN/ACT ON GROUP	F 244		

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F 244 SS=E	Continued From page 2 GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident council minutes, facility policy review, and interview, the facility failed to act upon a grievance of the resident council related to the delay in receiving night-time medications. The findings included: Review of resident council minutes dated March 28, April 17, May 30, June 19, and August 16, 2013, revealed the residents reported not receiving evening medications in a timely manner. Further review of the resident council minutes on August 16, 2013, recorded no resolution in receiving evening medication in a timely manner. Review of facility policy Complaint/Concern/Grievance/Request Procedure, revised May 1, 2012, revealed "...the facility shall investigate and resolve all complaints/concerns/grievances/requests promptly, responsibly and consistently..." Interview with the former Resident Council President, on September 24, 2013, at 8:35 a.m., in the resident's room, confirmed the resident	F 244	**F244 Listen/Act on Group Grievance/Recommendation** Resident Council minutes will be distributed to department head staff by the Activity Director or designee. The minutes will be reviewed at facility morning meeting on the next business day following the Resident Council meeting. A Business Action Plan will be formulated for grievances expressed by the resident council. Department head staff will be in serviced by administrator or designee related to the review of Resident Council minutes and Business Action plan formulation for grievances, completed 10/10/13. Business Action Plan's will be reviewed daily during scheduled facility morning meeting until grievance resolved. Resident council meeting minutes and Business Action Plans will be discussed at Continuous Quality Improvement meeting monthly x 3 months then quarterly thereafter if needed. Continuous Quality Improvement comprised of the DON, Medical Director, Risk Mmanager, Social Services Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care	10/25/13

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F 244	Continued From page 3 council discussions of the repeated delays in receiving the evening medications. Further interview revealed "...second shift is where they have the most problem..." Interview with the Activity Director, on September 25, 2013, at 7:45 a.m., in the East Wing nursing station, confirmed the Activity Director is "...the go to person..." who recorded the resident council meeting minutes and communicated concerns to administration. " Continued interview confirmed the facility failed to resolve the grievance in a timely manner.	F 244	Nurse, Medical Records Director and Administrator of Quality Assurance.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, for one hallway of six hallways, and for five rooms on one hallway of six hallways. The findings included: Observations on September 23-25, 2013, on the 500 hallway revealed, Room 504 with an approximately one eight inch crack in the center of the bathroom door which appeared to be previously patched. Continued observation revealed, Room 505 with a broken bathroom door	F 253	**F253 Housekeeping & Maintenance Services** Room 504 with an approximate 8 inch crack in center of bathroom door will be repaired by 11/9/13 Room 505 with broken bathroom door facing was repaired 10/11/13 and peeling paint will be repaired by 11/9/13 Room 509 with missing baseboard on right side of room was replaced on 10/4/13 Room 510 with multiple patching on walls and missing baseboard with an exposed edge will be repaired by 11/9/13 Room 508 with multiple areas of patched walls will be repaired by 11/9/13 Room 508 commode with dark ring around the base was cleaned on 10/8/13. The toilet paper holder was repaired on 9/27/13	11/9/13

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F 253	Continued From page 4 facing and multiple areas of peeling paint on the room walls. Continued observation revealed, Room 509 with a missing baseboard on the right side of the room for the entire length of the wall. Continued observation revealed, Room 510 with multiple areas of patching on the walls which were not sanded or painted, and a missing base board adjacent to the bathroom with an exposed edge on the wall corner near the bathroom door. Continued observation revealed, Room 508 with multiple areas of patched walls that were not sanded or painted, a toilet paper holder in the bathroom which was dislodged from the drywall, a dark ring around the base of the commode and the presence of a strong odor. Interview with the Maintenance Director on September 25, 2013 at 1:00 p.m. in Room 508 confirmed the rooms were in need of repair. Observation on September 23, 2013, at 8:00 a.m., and 10:00 a.m., revealed an offensive odor on the 300 hallway. Continued observation on September 24, 2013, at 8:05 a.m.,revealed an offensive odor noted on the 300 hallway . Observation and interview on September 24, 2013, at 8:10 a.m., with the Social Services Director, (SSD) on the 300 hallway, confirmed there was an odor on the 300 hallway, described as " dusty, musty, like a dirty rag" Continued interview revealed the SSD had smelled an odor on the hallway prior to September 24, 2013, and confirmed the odor was offensive.	F 253	Facility hallways were evaluated for offensive odor by Environmental Service Director and Interim DON and no issues were identified on 9/24/13. An audit to check need for repair of all facility resident rooms will be completed by Administrator or designee and Maintenance Director. Department head staff or designee will monitor resident rooms and facility hallways 4 rooms / hallways 3x week x 4 weeks, 4 rooms / hallways 2x week x 4 weeks, 4 rooms / hallways 1x week x 4 weeks then re-evaluate continued need to audit based on findings. Results of audit will be reviewed during Continuous Quality Improvement meeting monthly x 3 months the quarterly thereafter if needed. Continuous Quality Improvement meeting comprised of the DON, Medical Director, Risk Manager, Social Service Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care Nurse, Medical Records Director and Administrator of Quality Assurance.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 5 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a care plan to address impaired vision for one resident (#18) of forty-three residents reviewed. The findings included: Resident #18 was admitted to the facility on November 7, 2012, with diagnoses including Urinary Tract Infection, Congestive Heart Failure, Paraplegia, Aortic Stenosis, and Chronic Ischemic Heart Disease. Medical record review of the quarterly Minimum Data Set (MDS) dated July 28, 2013, revealed the resident had impaired vision, and corrective	F 279	**F279 Develop comprehensive care plans** Resident # 18 care plan was developed to reflect impaired vision by MDS nurse on 9/25/13. DON or designee will audit all in house residents with eyeglasses to ensure impaired vision is addressed and a care plan developed, completed on 10/9/13. MDS nurses were in serviced by regional nurse on need to develop care plan for resident with impaired vision on 10/10/13. DON or Designee will monitor residents who wear eye glasses and care plan development 4 residents 3x week x 4 weeks, 4 residents 2x week x 4 weeks, 4 residents 1x week x 4 weeks then re-evaluate need to continue audit based on findings. Results of audits will be reviewed during Continuous Quality Improvement meeting monthly x 3 months then quarterly thereafter if needed. Continuous Quality Improvement meeting comprised of the DON, Medical Director, Risk Manager, Social Service Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care	10/25/13

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F 279	Continued From page 6 lenses were not used. Medical record review of the Care Plan dated August 5, 2013, revealed no documentation to address the resident's impaired vision. Observation on September 24, 2013, at 1:00 p.m., revealed the resident seated in a wheelchair, in the resident's room, with glasses in place. Interview on September 24, 2013, at 3:05 p.m., with Licensed Practical Nurse (LPN) #4, in the conference room, confirmed a care plan for impaired vision had not been developed for the resident.	F 279	Nurse, Medical Records Director and Administrator of Quality Assurance. **F309 Provide care/services for highest well being** Primary physician notified of resident receiving rocephin 6 days instead of 7 and prednisone 9 days instead of 10 with no new orders received on 9/24/13.	10/25/13
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to administer medications as ordered for one resident (#18) of forty-three residents reviewed. The findings included: Resident #18 was admitted to the facility on	F 309	Nurse was counseled related to electronic medication order entry stop date completion by DON or designee. All in house residents with stop date medications were evaluated by Medical Records Director. This was completed on 9/26/13 with no issues found. All licensed staff will be in serviced by staff Development Coordinator or designee related to electronic order entry with stop date. DON or designee will monitor medication stop dates all residents with automatic stop date 1x week x 8 weeks then re-evaluate continued need to audit based on findings.	

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F 309	Continued From page 7 November 7, 2012, with diagnoses including Urinary Tract Infection, Congestive Heart Failure, Paraplegia, Aortic Stenosis, and Chronic Ischemic Heart Disease. Medical record review of a physician's progress note dated August 28, 2013, revealed "c/o (complains of) congestion...cough...Acute Bronchitis..." Medical record review of the physician's order dated August 28, 2013, revealed "Rocephin (antibiotic) 1 gm (gram) IM (intramuscular/by injection) qd (every day) x (times) 7 days...Prednisone (steroid/anti-inflammatory) 10mg (milligrams) (2) qd x 5 days then (1) qd x 5 days, then (1/2) qd x 10 days then d/c (discontinue)." Medical record review of the August and September 2013, electronic Medication Administration Record revealed the following: the resident received the Prednisone 10mg (2 tablets) August 29, 2013, through September 1, 2013, (four days instead of five days); received the Prednisone 10mg September 3-7, 2013, (as ordered); and received the Prednisone 1/2 tablet (5 mg) September 9-17, 2013, (9 days instead of 10 days). Medical record review of the electronic Medication Administration Record revealed the resident received the Rocephin 1 gram IM on August 28, 29, 30, and 31, 2013, and on September 1, and 2, 2013, (six days instead of seven days). Interview on September 24, 2013, at 3:25 p.m., with the Interim Director of Nursing, in the	F 309	Results of audits will be reviewed at CQI meeting monthly x 3 months then quarterly thereafter if needed. Continuous Quality Improvement meeting comprised of the DON, Medical Director, Risk Manager, Social Service Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care Nurse, Medical records Director and Administrator of Quality Assurance.	

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F 309	Continued From page 8 conference room, confirmed the resident did not receive the Rocephin as ordered. Interview on September 25, 2013, at 9:50 a.m., with the Interim Director of Nursing, in the conference room, confirmed the resident did not receive the Prednisone as ordered by the physician. c/o #32409	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility	F 322	**F322 NG Treatment/Services-Restore Eating skills** Resident # 100 and # 162 continuous feeding lines, reservoirs and flush solutions were replaced and dated by staff nurse on 9/23/13. All other in house residents with continuous tube feedings were evaluated on 9/23/13 by staff nurse and found to have their tube feeding lines, reservoirs and flush solutions dated appropriately. Licensed staff will be in serviced by staff development coordinator related to the daily changing and labeling of continuous feeding lines, reservoirs and flush solutions. DON or designee will monitor all residents with continuous tube feeding lines 3 x week x 4 weeks, 2x week x 4 weeks, 1x week x 1 week then re-evaluate continued need to audit based on findings. Results of audits will be reviewed at Continuous Quality Improvement meeting x 3 months then quarterly thereafter if needed.	10/25/13

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F 322	Continued From page 9 failed to label tube feeding solutions for two residents, (#100, #162), of forty-three residents reviewed. The findings included: Resident #100 was admitted to the facility on June 24, 2013, and readmitted on August 19, 2013, with diagnoses including Attention to Gastrostomy, Flu with Respiratory Manifestations, Dysphagia, Parkinson's Disease, Esophageal Stricture, and Malignant Hypertension. Observation during medication administration, on September 23, 2013, at 3:00 p.m., in the resident's room, revealed resident #100 lying on the bed with continuous tube feeding via gastrostomy tube (a surgically implanted tube into the stomach to provide nutrition) by feeding pump (an electronic pump that dispenses the feeding solution into the gastrostomy tube) in place. Continued observation revealed the tube feeding lines and reservoir labels were not dated. Continued observation revealed the feeding pump flush reservoir was not labeled or dated. Resident #162 was admitted to the facility on June 27, 2013, and readmitted on July 13, 2013, with diagnoses of Pneumonia, Sepsis, Diabetes Mellitus, Hypertension, Atrial Fibrillation, and Hyperosmolarity Not Otherwise Specified. Observation on September 23, 2013, at 3:10 p.m., in the resident's room revealed, resident #162 lying on the bed, with continuous tube feeding via gastrostomy tube in place. Continued observation revealed the tube feeding lines, tube feeding reservoir, and tube feeding flush reservoir were not labeled or dated.	F 322	Continuous Quality Improvement meeting comprised of the DON, Medical Director, Risk Manager, Social Service Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care Nurse, Medical Records Director and Administrator of Quality Assurance.	

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F 322	Continued From page 10 Interview with Licensed Practical Nurse (LPN) #2 on September 23, 2013, at 3:20 p.m., in the 200 hallway, confirmed tube feeding lines, and solution reservoirs were to be labeled with the date and time of administration and the facility failed to label the feedings for resident #100 and resident #162. Interview with the Interim Director of Nursing on September 24, 2013, at 10:30 a.m., in the 300 hallway, confirmed tube feeding solutions were to be labeled with the date and time of administration, and the facility failed to label and date tube feeding lines, reservoirs, and flush solutions for residents #100 and #162.	F 322	**F332 Free of medication error rates of 5% or more** LPN # 3 and LPN # 5 will be in serviced related to medication administration within an appropriate time frame as ordered for assigned residents by DON or designee. The consultant pharmacist will review the appropriateness of facility scheduled medication times.	10/25/13
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, facility document review, observation, and interview, the facility failed to ensure licensed staff administered medications within appropriate time frames as ordered in 64 of 94 opportunities resulting in a 68% medication error rate. The findings included: Review of facility policy, Medication Administration-General Guidelines, (no date), revealed "...Medications are administered within	F 332	Licensed staff will be in serviced by the Staff Development Coordinator on medication times and importance of residents receiving scheduled medications in a timely manner. DON or designee will audit evening medication pass 5 opportunities 3 x week x 4 weeks, 5 opportunities 2 x week x 4 weeks, 5 opportunities 1x week x 4 weeks then re-evaluate continued need to audit based on findings. Results of audits will be reviewed as Continuous Quality Improvement meeting monthly x 3 months then quarterly thereafter if needed. Continuous Quality Improvement meeting comprised of the DON, Medical Director,	

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BRIARCLIFF HEALTH CARE CENTER	100 ELMHURST DR OAK RIDGE, TN 37830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 11 (60 minutes) of scheduled time..." Review of facility document Med Pass Time (no date), revealed "...twice daily=9am - 9pm...three times daily= 9am - 3pm - 9pm...four times daily=9am - 1pm - 5pm- 9pm...hour of sleep=...9pm... Medical record review revealed resident #63 was admitted to the facility on July 19, 2011, with diagnoses including Diabetes, Hypertension, Chronic Kidney Disease, Hypothyroidism, and Mental Disorder. Medical record review of a physician's recapitulation order for September 2013, revealed "...Depakote DR (delayed release) (mood stabilizer) 125 mg (milligrams) 1 tablet...twice daily...Hydralazine (blood pressure) 50 mg...twice daily...Lopid (high cholesterol) 600 mg...twice daily...Senna S (laxative)...twice daily...Colace (stool softener) 100 mg...twice daily..." Observation of a medication administration on September 24, 2013, at 10:43 p.m., revealed resident #63 received the Depakote DR 125mg, Hydralazine 50mg, Lopid 600mg, Senna S, and Colace 100mg one hour and forty-three minutes after the 9:00 p.m. scheduled administration time. Medical record review revealed resident #4 was admitted to the facility on June 12, 2013, for diagnoses including Cardiomegaly, Muscle Weakness, Cerebral Artery Occlusion, and Fractured Humerus. Medical record review of a physician's recapitulation order for September 2013, revealed "...Flexeril (muscle relaxer) 10 mg...3 times	F 332	Risk Manager, Social Service Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care Nurse, Medical Records Director and Administrator of Quality Assurance.	

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F 332	Continued From page 12 daily...Oxybutynin (overactive bladder) 5 mg...3 times daily..." Medical record review of a physician's order written September 13, 2013, revealed "...Keppra (anti-epileptic) 500 mg...bid (twice daily)..." Medical record review of a physician's order written September 19, 2013, revealed "...Exelon 6 mg (decreases confusion)...bid..." Observation of a medication administration on September 24, 2013, at 10:54 p.m., revealed resident #4 received the Flexeril 10mg, Oxybutynin 5mg, Keppra 500mg, and Exelon 6mg one hour and fifty-four minutes after the 9:00 p.m. scheduled administration time. Medical record review revealed resident #14 was admitted January 10, 2012, with diagnoses including Diabetes, Hypertension, Paralysis, Breast Cancer, Dementia, Osteoarthritis, and Traumatic Fracture. Medical record review of a physician's recapitulation order dated September 2013, revealed "...Glucotrol (diabetes) 5 mg...twice daily...Metoprolol (blood pressure) 50mg...twice daily...Senna S (laxative)...twice daily...Lasix (fluid retention) 40 mg...twice daily...Calcium 600 mg plus Vitamin D 400 mg ...twice daily...Stool Softener...twice daily...Arimidex (breast cancer) 1 mg...bedtime...Requip (Parkinson's) XL (extended release) 12 mg...bedtime...Lipitor (high cholesterol) 10mg ...bedtime...Hydralazine (hypertension) 100mg...three times daily...Potassium CL (chloride) ER (extended release) 20 MEQ (milliequivalents) (mineral)...three times daily..."	F 332		

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F 332	Continued From page 13 Observation of a medication administration on September 24, 2013, at 10:59 p.m., revealed resident #14 received the Glucotrol 5mg, Metoprolol 50mg, Senna S, Lasix 40mg, Calcium 600 mg plus Vitamin D 400mg, Stool Softener, Arimidex 1 mg, Requip XL 12 mg, Lipitor 10mg, Hydralazine 100mg, Potassium CL ER 20 meq one hour and fifty-nine minutes after the 9:00 p.m. scheduled administration time. Medical record review revealed resident #56 was admitted to the facility on June 15, 2006, with diagnoses including Failure to Thrive, Depressive Disorder, Anxiety, Malaise, Hypertension, Benign Prostatic Hyperplasia, and Urinary Retention. Review of a physician's recapitulation order dated September 2013, revealed "...Depakote 125 mg...twice daily...Mirtazapine (antidepressant) 7.5mg...bedtime..." Review of a physician's order written September 23, 2013, revealed "...Coumadin (blood thinner) 6mg po (by mouth) q (every) hs (hour of sleep)..." Observation of a medication administration on September 24, 2013, at 11:08 p.m., revealed resident #56 received the Depakote 125mg, Mirtazapine 7.5mg, and Coumadin 6mg two hours and eight minutes after the 9:00 p.m. scheduled administration time. Medical record review revealed resident #12 was admitted to the facility on February 4, 2013, with diagnoses including Urinary Obstruction, Prostatitis, Encephalopathy, Gastroesophageal Reflux Disease, Renal Disease, and Diabetes.	F 332		

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F 332	Continued From page 14 Medical record review of a physician's recapitulation order dated September 2013, revealed "...Zantac (inhibits stomach acid) 150mg ...twice daily...Ranexa (Coronary Artery Disease) 1000 mg...twice daily...Simvastatin (high cholesterol) 20mg...hs...Flomax (urinary obstruction) 0.4 mg...hs...Midodrine (low blood pressure) 10mg ...three times daily..." Medical record review of a physician's order dated September 17, 2013, revealed "...Amikacin (antibiotic) 250mg...IM (intramuscular) bid..." Observation of a medication administration on September 24, 2013, at 11:20 p.m., revealed resident #12 received the Zantac 150mg, Ranexa 1000mg, Simvastatin 20mg, Flomax 0.4mg, Midodrine 10mg, and the Amikacin 250mg two hours and twenty minutes after the 9:00 p.m. scheduled administration time. Medical record review revealed resident #97 was admitted to the facility on September 19, 2011, and readmitted on August 25, 2012, with diagnoses including Encephalopathy, Hypertension, Diabetes, Pernicious Anemia, Hypothyroidism, and Vascular Dementia. Medical record review of a physician's recapitulation order dated September 2013, revealed "...Ferrous Sulfate (Iron) 325 mg...twice daily...Flomax 0.4mg ...hs...Lyrica (nerve pain) 25 mg...hs...Lexapro (depression) 10 mg...hs...Aricept (dementia) 10mg...hs...Ativan (anxiety) 0.5mg...hs..." Observation of a medication administration on September 24, 2013, at 11:34 p.m., revealed	F 332		

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F 332	Continued From page 15 resident #97 received the Ferrous Sulfate 325 mg, Flomax 0.4mg, Lyrica 25mg, Lexapro 10mg, Aricept 10mg, and the Ativan 0.5mg two hours and thirty-four minutes after the 9:00 p.m. scheduled administration time. Medical record review revealed resident #26 was admitted to the facility on December 4, 2007, with diagnoses including Alzheimer's Disease, Congestive Heart Failure, Osteoarthritis, Hypertension, Psychosis, and Depressive Disorder. Medical record review of a physician's recapitulation order dated September 2013, revealed "...Namenda (Alzheimer's) 10mg...twice daily...Aricept 10mg...hs...Seroquel (antipsychotic) 25mg...hs...Lortab (pain) 10 mg...tid Observation of a medication administration on September 24, 2013, at 11:50 p.m., revealed resident #26 received the Namenda 10mg, Aricept 10mg, Seroquel 25mg, and the Lortab 10mg two hours and fifty minutes after the 9:00 p.m. scheduled administration time. Medical record review revealed resident #70 was admitted to the facility on February 28, 2009, with diagnoses including Malaise, Osteoarthritis, Cardiomegaly, Venous Insufficiency, Iron Deficiency, and Hypothyroidism. Medical record review of a physician's recapitulation order dated September 2013, revealed "... Oxycontin (pain) 10 mg...twice daily...Senna S twice daily..." Observation of a medication administration on	F 332		

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F 332	Continued From page 16 September 25, 2013 at 12:04 a.m., revealed resident #70 received the Oxycontin 10mg and the Senna S three hours and four minutes after the 9:00 p.m. scheduled administration time. Interview with Licensed Practical Nurse (LPN) #5 on September 24, 2013, at 11:38 p.m., outside room 512, confirmed LPN #5 administered medications to residents #63, #4, #14, #56, #12, #97, #26, and #70 late. Further interview revealed "...it is usually around 11 when I finish..." Interview with the Interim Director of Nursing on September 25, 2013, at 3:35 p.m., in the Administrator's office, confirmed medications were given late. Resident #68 was admitted to the facility on August 9, 2013, with diagnoses including: Malignant Hypertension, Chronic Kidney Disease Stage III, and Rectal and Anal Disease. Medical record review of the September 2013, physcian's recapitulation orders revealed Resident #68 was to receive "...Novolin R (fast acting insulin used to treat Diabetes Mellitus) 100 units/ml vial subcutaneously per sliding scale 4 times daily...0-150 = 0 units, 151-200 =2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, Greater than 401 = 10 units recheck in 2 hours if still above 401 notify MD/NP (Medical Doctor/ Nurse Practitioner)... Levemir (long acting insulin for Diabetes Mellitus) 100 units/ml vial Give 30 units subcutaneous twice daily. Observation on September 24, 2013 at 10:46 p.m., revealed LPN #3 administered Novolin R	F 332		

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F 332	Continued From page 17 10 units subcutaneous and Levemir 30 units subcutaneous. Observation revealed the Levemir was administered one hour and forty-six minutes after the 9:00 p.m. scheduled administration time, and the Novolin R was two hours and forty-six minutes after the 8:00 p.m. scheduled administration time. Resident #100 was admitted to the facility on August 19, 2013, with diagnoses including: Gastrostomy, Anemia, Paralysis, Dysphagia, and Malignant Hypertension. Review of the September 2013, physician's recapitulation orders revealed Resident #100 was to receive "...Mysoline (Primidone - anticonvulsant used for treatment of Epilepsy) 50 mg tablet- give 1 tablet per peg tube twice daily...Propanolol (used to treat cardiac dysrhythmias, Angina, and Hypertension) 20 mg tablet - give 1 tablet per tube twice a day...Zantac (Ranitidine- used to treat duodenal ulcers)150 mg per peg tube twice daily...Sinemet (used to treat Parkinsons)10-100 mg Tablet = give 1 tablet via peg tube 3 times daily... Tamsulosin HCL 0.4mg capsule - via peg tube daily..." Observation on September 24, 2013, at 10:58 p.m., revealed LPN #3 administered the Mysoline,Propanolol, Zantac, and the Sinemet, one hour and fifty-eight minutes after the 9:00 p.m. scheduled administration time. Resident #179 was admitted to the facility on September 4, 2013, with diagnoses including: Altered Mental Status, Urinary Tract Infection, Diabetes Mellitus type II, Hypertension, Aphasia, and Hypothyroidism.	F 332		

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F 332	Continued From page 18 Medical record review of the September 2013, physician's recapitulation orders revealed Resident #179 was to receive "...Caltrate (calcium supplement) 600 tablet - give 1 tablet by mouth daily...Simvastatin (used to treat high cholesterol) 20 mg- give 1 tablet by mouth at bedtime..." Observation on September 24, 2013, at 11:25 p.m., revealed LPN #3 administered the Caltrate and the Simvastatin, two hours and twenty-five minutes after the 9:00 p.m. scheduled administration time. Resident #30 was admitted to the facility on August 2, 2013, with diagnoses including: Acute and Chronic Respiratory Failure, Pneumonia, Asthma, Pleural Effusion, Chronic Kidney Disease Stage II, Cirrhosis of the Liver, Diabetes Mellitus type II, and Hypertension. Medical record review of the September 2013, physician's recapitulation orders revealed Resident #30 was to receive "...Levemir (long acting insulin for Diabetes Mellitus) 100 units/ml (milliliter) Administer 16 units subcutaneous once daily, Gabapentin (lipophilic amino acid used for the treatment of peripheral neuropathy, migraines, and pain disorders)300 mg (milligrams) capsule 1 by mouth everyday 3 times a day...Ferosul (iron supplement for treatment of anemia) 325 mg 1 tablet by mouth twice daily... Vitron - C (iron supplement with vitamin c added) 1 tablet twice a day...Carvedilol (beta blocker used for heart failure, hypertension and heart attacks) 25 mg 1 tablet by mouth twice daily... Magnesium Oxide (mineral supplement used for low levels in the blood) 400 mg tablet by mouth twice daily...Pantoprazole Sodium (used to treat acid reflux)40 mg tab give 1 tablet by mouth	F 332		

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F 332	Continued From page 19 twice a day...Advair (synthetic corticosteroid anti-inflammatory used to treat asthma) 250/50 Diskus - inhale 1 puff twice a day...Aldactone (used for cirrhosis of the liver, Congestive Heart Failure, Hypertension) 25 mg by mouth two times daily...Zolpidem Tartrate (Ambien used to treat insomnia) 5 mg tablet give 1 tablet by mouth at bedtime...Montelukast Sodium (Singulair used to treat asthma) 10 mg tablet give one tablet at bedtime... keterorolac 0.5% ophth solution (non-steroidal anti-inflammatory solution used after cataract surgery) - 2 drops each eye at bedtime...Levaquin (antibiotic used for bacterial exacerbation of chronic bronchitis) 500 mg tablet by mouth daily times 7 days...Humilin R (fast acting insulin used to treat Diabetes Mellitus) 100 units/ml vial subcutaneously per sliding scale 4 times daily...0-150 = 0 units, 151-200 =2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, Greater than 401 = 10 units recheck in 2 hours if still above 401 notify MD/NP (Medical Doctor/ Nurse Practioner)..." Observation on September 24, 2013, at 11:40 p.m., revealed LPN #3 administered the Levemir, Gabapentin, Ferosol, Vitron C, Carvedilol, Magnesium Oxide, Pantoprazole sodium, Advair, Aldactone, Zoldiem tartrate, Singulair, Keterorolac opthalmic solution, Levaquin, and Humulin R, were administered two hours and forty minutes after the 9:00 p.m. scheduled administration time. Interview with LPN #3 on September 24, 2013 during the medication administration, confirmed the medications were administered late. Interview with the Interim Director of Nursing on September 25, 2013, at 3:35 p.m., in the	F 332		

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F 332	Continued From page 20 Administrator's office, confirmed medications were given late.	F 332	**F333 Residents free of significant med errors** Medical Director was notified on 10/7/13 by regional nurse that resident # 68 and #30 were given medications late with no further orders received. LPN # 3 and LPN # 5 will be in serviced related to medication administration within an appropriate time frame as ordered for assigned residents by DON or designee. Licensed staff will be in serviced by Staff Development coordinator on medication time and importance of residents receiving scheduled medications in a timely manner. DON or designee will audit evening medication pass 5 opportunities 3x week x 4 weeks, 5 opportunities 2x week x 4 weeks, 5 opportunities 1x week x 4 weeks then re-evaluate continued need to audit based on findings. Results of audits will be reviewed at Continuous Quality Improvement meeting monthly x 3 months then quarterly thereafter if needed. Continuous Quality Improvement meeting comprised of the DON, Medical Director, Risk Manager, Social Service Director,	10/25/13
F 333 SS=D	C/O #32350 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and interview the facility failed to prevent significant medication errors for two residents (#68, #30) of forty-three residents reviewed. The findings included: Resident #68 was admitted to the facility was admitted to the facility on August 9, 2013, with diagnoses including: Malignant Hypertension, Chronic Kidney Disease Stage III, and Rectal and Anal Disease. Review of the September 2013, physician's recapitulation orders revealed Resident #68 was to receive "...Novolin R (fast acting insulin used to treat Diabetes Mellitus) 100 units/ml vial subcutaneously per sliding scale 4 times daily...0-150 = 0 units, 151-200 =2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, Greater than 401 = 10 units recheck in 2 hours if still above 401 notify MD/NP	F 333		

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F 333	Continued From page 21 (Medical Doctor/ Nurse Practioner)... Levemir (long acting insulin for Diabetes Mellitus) 100 units/ml vial Give 30 units subcutaneous twice daily." Continued review of the Electronic Medication Administration Record (eMAR) dated September 2013 revealed the Novolin R Insulin was to be administered at 8:00 p.m. Observation of the medication administration on September 24, 2013, at 10:46 p.m., revealed the resident had a blood glucose level 408 and received Novolin R 10 units subcutaneously, two hours and forty-six minutes after the 8:00 p.m. scheduled administration time. Resident #30 was admitted to the facility on August 2, 2013, with diagnoses including: Acute and Chronic Respiratory Failure, Pneumonia, Asthma, Pleural Effusion, Chronic Kidney Disease Stage II, Cirrhosis of the Liver, Diabetes Mellitus type II, and Hypertension. Review of the September 2013, physician's recapitulation orders revealed Resident #30 was to receive "...Humulin R (fast acting insulin used to treat Diabetes Mellitus) 100 units/ml vial subcutaneously per sliding scale 4 times daily...0-150 = 0 units, 151-200 =2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, Greater than 401 = 10 units recheck in 2 hours if still above 401 notify MD/NP (Medical Doctor/ Nurse Practitioner)..." Observation on September 24, 2013, at 11:40 p.m., revealed the resident's blood glucose was 483 and LPN #3 administered the Humulin R 10 units to the resident two hours and forty minutes	F 333	Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care Nurse, Medical Records Director and Administrator of Quality Assurance.	

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F 333	Continued From page 22 after the 9:00 p.m. scheduled administration time. Interview with LPN #3 on September 24, 2013 during the medication administration confirmed the residents' blood glucose levels were elevated and the "fast acting insulins" were administered late. Interview with the Interim Director of Nursing on September 25, 2013, at 3:35 p.m., in the Administrator's office, confirmed medications were given late.	F 333		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to ensure laboratory tests were obtained for one resident (#38) of forty-three residents reviewed. The findings included: Resident #38 was admitted to the facility on December 19, 2012, with diagnoses including Acute Kidney Failure, Osteoporosis, Hypertension, and Psychosis. Medical record review of the Physician's Orders dated September 2013, revealed "...CBC (complete blood count)...TSH (Thyroid Stimulating Hormone)...Every 6 Months..."	F 502	**F502 Administration** Laboratory tests (CBC and TSH) were drawn for resident # 38 and reviewed by physician on 9/24/13 with no new orders. An audit of routine laboratory tests will be completed on in house residents by DON or designee. The unit managers will be in serviced by DON or designee to ensure that scheduled laboratory tests are obtained as ordered on 10/10/13. A laboratory calendar will be maintained by the unit managers, each lab draw will be verified against this calendar on lab draw days.	10/25/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445260	A. BUILDING _____ B. WING _____	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH CARE CENTER	100 ELMHURST DR OAK RIDGE, TN 37830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 23 Medical record review revealed the CBC and TSH had been obtained on February 14, 2013. Further review of the medical record revealed no laboratory results for the CBC and TSH in August 2013. Interview on September 24, 2013, at 2:45 p.m., with RN #1 (Registered Nurse), confirmed the TSH and CBC had not been completed in August (every 6 months) as ordered.	F 502	DON or designee will audit laboratory schedule 4 residents 2 x week x 8 weeks then re-evaluate continued need to audit based on findings. Results of audits will be reviewed at Continuous Quality Improvement meeting monthly x 3 months then quarterly thereafter if needed.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	Continuous Quality Improvement meeting comprised of the DON, Medical Director, Risk Manager, Social Service Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care Nurse, Medical Records Director and Administrator of Quality Assurance. **F520 Committee –members/meet quarterly/plans** Resident Council minutes will be presented at Continuous Quality Improvement meeting by the Activities Director or designee. The Activities Director or designee will distribute resident council minutes to department head staff. The minutes will be reviewed at facility morning meeting on the next business day following the Resident Council meeting.	10/25/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on review of Resident Council minutes, observation, and interview, the facility failed to identify a problem with the administration of medications. The findings included: Review of the Resident Council minutes dated March 28, 2013, April 17, 2013, May 30 2013, June 19, 2013, and August 16, 2013, revealed the residents had complained of receiving medications later than the medications were scheduled to be administered. Observations on September 24, 2013, at 10:43 p.m., through September 25, 2013, at 12:04 a.m., revealed the medications scheduled to be administered at 8:00 p.m., and 9:00 p.m., on September 24, 2013, were not administered until September 24, 2013, at 10:43 p.m., through September 25, 2013, at 12:04 a.m., on two of six units. Interview on September 25, 2013, at 3:20 p.m., with the Interim Director of Nursing and the Administrator, in the Administrator's office, confirmed the facility had not identified the problem with the administration of medications. Refer to F332	F 520	Activity Director will be in serviced by administrator or designee to present Resident Council minutes to the Continuous Quality Improvement Committee. Continuous Quality Improvement meeting comprised of the DON, Medical Director, Risk Manager, Social Service Director, Dietary Director, Rehab Director, Staff Development Coordinator, Admissions Director, Restorative Nurse, Wound Care Nurse, Medical Records Director and Administrator of Quality Assurance.	

OCT 11 2013